02275

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 35 Old Annapolis Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: North Linthicum
STREET ADDRESS (If rural, give location): 30 Old Annapolis Rd.

3. NAME OF DECEASED (Type or Print) (First): LENA (Middle): M. (Last): ANDERS
4. DATE OF DEATH (Month): Mar. (Day): 28, (Year): 1949

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed
8. DATE OF BIRTH: Mar. 17, 1866
9. AGE last birthday: 83 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Vallisca, Iowa
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob Crist
14. MOTHER'S MAIDEN NAME: Sarah Spiedel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. J. W. L. Zimmerman 35 Old Annapolis Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardio-Vascular Disease — 6 yr.

443 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension — 10 yr.

(c) Arteriosclerosis — 10 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1943, 19....., to 3/28, 1949, that I last saw the deceased alive on 3-28, 1949, and that death occurred at 7 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Chas. L. Ball Jr. — ADDRESS: Mon Linthicum — DATE SIGNED: 3/28.49

23. ~~BURIAL, CREMATION~~ REMOVAL (Specify): Removal — DATE: 3/30/49 — NAME OF CEMETERY OR CREMATORY: Greenmount Cem. — LOCATION (City, town, or county) (State): York, Pa.

DATE REC'D BY LOCAL REG.: 3/29/49 — REGISTRAR'S SIGNATURE: F. W. Hedrick DM

24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum | LENGTH OF STAY (in this place) 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 700 S. Hammonds

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum - Md.
STREET ADDRESS (If rural, give location) 700 So. Hammonds Ferry Rd.

3. NAME OF DECEASED (Type or Print): (First) Maurice (Middle) Agustus (Last) Atzrodt
4. DATE OF DEATH: (Month) March (Day) 14 (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	May 20-1875	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Auto Painter	Auto.	Hanover - Pa.	America

13. FATHER'S NAME Harry Atzrodt
14. MOTHER'S MAIDEN NAME Anna McFarland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 216-07-4925
17. INFORMANT Maurice D. Atzrodt

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardio - Vascular Disease	30 min
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	10 yrs.
443 93d	(c) Hypertension	8 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cerebral Haemorrhage	7 yrs.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan -, 1948, to Mar. 14, 1949, that I last saw the deceased alive on Mar. 14, 1949, and that death occurred at 2:30 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Chas. L. Ball Jr. M.D.		Linthicum - Md.	

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR ~~CREMATORY~~	LOCATION (City, town, or county) (State)
Burial	3/16/49	Lorraine	Balto. Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-15-49	W. W. Hedrick M.D.	Wm. Cook Inc.	1217 St. Paul St.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

BC 02277

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel County MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY ~~Baltimore~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) ~~Crownsville~~, ~~Maryland~~ Unk.

3. NAME OF DECEASED (Type or Print) (First) James (Middle) (Last) Baker

4. DATE OF DEATH (Month) March (Day) 5, (Year) 1949

5. SEX Male

6. COLOR OR RACE Black

7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH 4/25/30

9. AGE last birthday 18 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cartage, North Caroline

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henderson Baker

14. MOTHER'S MAIDEN NAME Annie McLaughlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Catatonic stupor

300.2 Antecedent cause(s)

84b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Schizophrenia

(c)

INTERVAL BETWEEN ONSET AND DEATH: Known to us since his admission 2/21/49

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 21, 1949, to March 5, 1949, that I last saw the deceased alive on March 5, 1949, and that death occurred at 10:40 a.m., from the causes and on the date stated above.

SIGNATURE Jacob Marycrestern M.D. (Degree or title) ADDRESS Superintendent, Crownsville, Maryland DATE SIGNED March 5, 1949

23. BURIAL, CREMATION REMOVAL (Specify) DATE 3/8/49 NAME OF CEMETERY OR CREMATORY Sanford N. C. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 3-7-49 REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR A. Halstead - ADDRESS 918 - David Hill Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02278

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis; LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: West Annapolis, Md

STREET ADDRESS (If rural give location): 715 ½ Monterey Ave

3. NAME OF DECEASED (Type or Print): (First) IDA (Middle) R.. (Last) BASIL

4. DATE OF DEATH: (Month) 3 (Day) 8 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 3-20-1882

9. AGE last birthday: 66 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wesley Sears

14. MOTHER'S MAIDEN NAME: Mary Ann Elizabeth Woods

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Harry F. Basil

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — Sudden

331 Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension — unknown

(c) Arteriosclerosis — Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-5- 10 A M, 19 49, to 3-8- 3 P M, 19 49, that I last saw the deceased alive on 3-8, 19 49, and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE: George B Basil (Degree or title) M.D. ADDRESS: Annapolis Md DATE SIGNED: 3-9-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 3-11-49 ~~3-11-49~~

NAME OF CEMETERY OR CREMATORY: Edward's Chapel

LOCATION (City, town, or county) (State): Riva Rd. nr Annapolis, Md.

DATE REC'D BY LOCAL REG.: March 11, 1949

REGISTRAR'S SIGNATURE: W. T. Branch

24. FUNERAL DIRECTOR: Ben L. Hopping and Son ADDRESS: Annapolis, Md.

RECEIVED
MAR 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

12279

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A.A. MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD; COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS; STREET ADDRESS (If rural give location) 115 LAFAYETTE AVE.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WILLIAM	WALLACE	BEALER	3	28	1949

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE		11-2-1872	76 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RET	U.S. NAVAL ACADEMY	ANNAPOLIS MD	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM BEALER	ELLEN HOPKINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		CARRIE J. BEALER

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.1 Immediate cause	(a) Coronary Thrombosis	Sudden
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	Several Yrs
	(c) Hypertension	Several Yrs

II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ....., 19..., to 3-28, 1949, that I last saw the deceased alive on 3-28, 1949, and that death occurred at 1 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Grace C. Paul	M.D.	Annapolis	3-29-49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	3-31-49	ST ANNES	ANNAPOLIS MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 31, 1949		JOHN M. TAYLOR	ANNAPOLIS MD

RECEIVED
APR 1 1949
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

816.5 02280

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN near Millersville
LENGTH OF STAY (in this place) —
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Massachusetts COUNTY Hampden
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Holyoke
STREET ADDRESS (If rural, give location) 651 Main

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) (Last) Belsky
4. DATE OF DEATH (Month) 3 (Day) 17 (Year) 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced
8. DATE OF BIRTH 6/29/87
9. AGE last birthday 61 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pres. Chas. H Belsky & Son
10b. KIND OF BUSINESS OR INDUSTRY Paper Supply Mfg Co.
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME UNKNOWN
14. MOTHER'S MAIDEN NAME UNKNOWN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. 014-05-5464
17. INFORMANT Edw. F. Day, F.D. Holyoke, Mass.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

816.5 Immediate cause (a) Fractured skull

Antecedent cause(s)

170c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Crushed chest

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. numerous lacerations + compound fractures

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 301 (CITY OR TOWN) near Millersville (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) Mar. (Day) 17 (Year) 1949 (Hour) 3:10 p.m.
INJURY OCCURRED While at Work ☐ Not While At work ☑
HOW DID INJURY OCCUR? Collision c̄ oil truck

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination, ~~19~~, ~~to~~ Mar., 1949, ~~that I last saw the deceased alive on~~, ~~19~~, and that death occurred at 3:10 p.m., from the causes and on the date stated above.

SIGNATURE John M. Claffy, M.D., (Degree or title) Deputy Medical Examination, ADDRESS Annapolis Md DATE SIGNED 3/17/49

23. BURIAL, CREMATION REMOVAL (Specify) Ship for Burial
DATE 3-18-48
NAME OF CEMETERY OR CREMATORY RAIDPHEY SHOLEM
LOCATION (City, town, or county) (State) CHICOPEE, MASS.
DATE REC'D BY LOCAL REG. 3/18
REGISTRAR'S SIGNATURE L. J. De Alba
24. FUNERAL DIRECTOR Thomas W Burghton ADDRESS Glen Burnie, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 21 1949
BUREAU V. S.

02281

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. L4747

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Pumphrey (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred: 6034 Bellegrove Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Pumphrey (If outside city or town limits, write RURAL and give nearest town)

Street No. 6034 Bellegrove Road (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Westley Boardley Jr

3. (b) Social Security Number

4. Sex: M

5. Color or race: C.

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Bertha Boardley

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.): April 2, 1869

8. AGE: Years 79 | Months 1 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace: Yellow Bank, Cal. Md. (Town, county, and state)

10. Usual occupation: Minister

11. Industry or business

FATHER
12. Name: John Westley Boardley
13. Birthplace: Calvert Co. Md.

MOTHER
14. Maiden name: Frances Lane
15. Birthplace: Calvert Co. Md.

16. Informant: Bertha Boardley

Address: 6034 Bellegrove Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 8, 1949 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Baltimore, Md.

18. Funeral director: Mrs Katie R. Williams

Address: 322 N Schroeder St.

19. 3/8/49 (Date rec'd by registrar) 19 ..... A. W. Heduck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~February~~ March 4 1949, at 12:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 1947, to March 4 1949 and that I last saw him alive on March 4 1949

Immediate cause of death: Coronary Thrombosis

Due to: Arterio-sclerotic heart disease.

Due to: 420.0 93d

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Ronald B Lighston M.D. M.D. or other

Address: 501 Cherry Hill Road Date signed: 3-4-49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12282

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) 12 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 17 Calvert St.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) E. (Last) Calhoun

4. DATE OF DEATH: (Month) March (Day) 22 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Dec. 8, 1906

9. AGE last birthday: 42 yrs. — If under 1 year: Months 3, Days 14 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter

10b. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: William H. Calhoun

14. MOTHER'S MAIDEN NAME: Daisy Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Helen Calhoun

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage into right ventricle	about 24 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Aneurism rupture	about 24 hours
	(c) probable Luetic origin	unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arterial hypertension — unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination, ~~, 19..., to~~ Mar. 23., 19 49., that I last saw the deceased ~~alive on ..., 19...~~, and that death occurred at 11 55 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Caffey M.D.	Deputy Medical Examiner	Annapolis Md	3/25/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Mar. 27, 1949	Brewer Hill	Annapolis Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Mar. 26, 1949	[signature]	J.B. Johnson	Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02283

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY A. A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glenburnie
LENGTH OF STAY (in this place) 14 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY AA Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
STREET ADDRESS (If rural, give location) Old Annapolis Road

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Henry (Last) Carnes
4. DATE OF DEATH (Month) March (Day) 3 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower
8. DATE OF BIRTH 3-15-1859
9. AGE last birthday 89 yrs. If under 1 year: Months | Days. If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Carnes
14. MOTHER'S MAIDEN NAME Mary E. Crabster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Sue F. Nash

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardio-Vascular Disease	1 mo.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio-Sclerosis	5 yrs.
	(c)	

422.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1944, to Mar 3, 1949, that I last saw the deceased alive on 3-3-, 1949, and that death occurred at 5 A m., from the causes and on the date stated above.

SIGNATURE Chas. L. Ball Jr. (Degree or title) MD ADDRESS Linthicum Md. DATE SIGNED 3-3-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF March 5-49
NAME OF CEMETERY OR CREMATORY St Marys
LOCATION (City, town, or county) Balto Md (State)

DATE REC'D BY LOCAL REG. 3/4/49
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR Robt C. & B. M. Walters ADDRESS Pratt & Stricker St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Evidence to change #18-part 2 shown on:

FILM No. G 120 MAY 24 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02284

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GAMBRILLS
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A.A.Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GAMBRILLS A.A.Co.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) BENJAMIN (Middle) FRANKLIN (Last) CHANEY

4. DATE OF DEATH (Month) 3 (Day) 12 (Year) 1949

5. SEX MALE

6. COLOR OR RACE WHITE

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH 7-18-1881

9. AGE last birthday 67 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER

10b. KIND OF BUSINESS OR INDUSTRY FARMER

11. BIRTHPLACE (State or foreign country) A-A-Co. MD

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ALFRED R. CHANEY

14. MOTHER'S MAIDEN NAME VIRGINIA BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No. —

17. INFORMANT JOHN A. CHANEY

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	3 months
331 Antecedent cause(s)	(b) Left hemiplegia	3 months
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) II Interstitial Nephritis	2 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1947, to 3/10, 1949, that I last saw the deceased alive on 3/10, 1949, and that death occurred at 6.20 A. m., from the causes and on the date stated above.

SIGNATURE Gustave W. Fischer M.D. (Degree or title) ADDRESS Glen Burnie, Md. DATE SIGNED 3/12/49.

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE 3/15/49 NAME OF CEMETERY OR CREMATORY FORT LINCOLN LOCATION (City, town, or county) PRINCE GEO. Co. MD. (State)

DATE REC'D BY LOCAL REG. 3/15/49 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR JOHN H. TAYLOR + SON ADDRESS ANNAPOLIS, MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
MAR 16 1949
BUREAU V. S.

Evidence to change order of # 18:

02285

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 120 MAY 5 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 801 Severn Avenue

3. NAME OF DECEASED (Type or Print) (First) Bohumila (Middle) (Last) Cihlar
4. DATE OF DEATH (Month) March (Day) 19 (Year) 49

5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH 7/4/1884
9. AGE last birthday 64 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Czechoslovakia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Taborsky
14. MOTHER'S MAIDEN NAME Frances Sibal

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Bozena Vlna, 801 Severn Ave., Eastport

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis

420.1 Antecedent cause(s)

552 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis Generalized

(c) Generalized Carcinomatosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1948, to March 19, 1949, that I last saw the deceased alive on March 19, 1949, and that death occurred at 10:30 A m., from the causes and on the date stated above.

SIGNATURE E Lin Hudd (Degree or title) M.S. ADDRESS Eastport, Maryland DATE SIGNED 3/17/49.

23. BURIAL, CREMATION REMOVAL (Specify) Cremation
DATE 3/22/49
NAME OF CEMETERY OR CREMATORY Greenmount Crematory
LOCATION (City, town, or county) Greenmount & Oliver (State)

DATE REC'D BY LOCAL REG. 3/21/49
REGISTRAR'S SIGNATURE Ada Hedrick
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 2601-3-5 E. Madison Street

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02286

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Green Haven, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:
Third Street

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Green Haven
(If outside city or town limits, write RURAL and give nearest town)

Street No. Third Street
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME: Michael Joseph Cook

3.(b) Social Security Number: 218-10-5184

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith Cook

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): January 14, 1885

8. AGE: Years	Months	Days	If less than one day
64	1	25	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Maryland Match Co.

FATHER
12. Name: John Cook
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Catherine Mink
15. Birthplace: Baltimore, Maryland

16. Informant: Mr. Allen T. Warfield
Address: Third St., Green Haven, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 12, 1949 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cemetery

Location: Baltimore, Md.

18. Funeral director: Ellis Funeral

Address: 1003 W. Baltimore St.

19. 3/10 19 49 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9 1949, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946, to March 9 1949 and that I last saw h.i.m alive on March 7 1949

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Arteriosclerotic Heart Disease	5 years
Due to: Chronic Myocarditis	3 years
Other conditions: 420.0 934	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Brady Smith M.D.
M. D. or other

Address: Butlers Beach Md. Date signed 3/9/49

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02287

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 17 MADISON St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD COUNTY A A; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS; STREET ADDRESS (If rural give location) MADISON ST.

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) (Last) CURRY

4. DATE OF DEATH: (Month) 3 (Day) 30 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 10/7/1886

9. AGE last birthday: 62 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CH. POLICE ANNAPOLIS

10b. KIND OF BUSINESS OR INDUSTRY: CHIEF POLICE

11. BIRTHPLACE (State or foreign country): ANNAPOLIS MD

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: WILLIAM CURRY

14. MOTHER'S MAIDEN NAME: EMILY Gaither

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MRS BLANCHE H CURRY

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: Sudden

420.1 94a

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension — 2 years

(c) Arteriosclerosis — 2 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1946, to March 30, 1949, that I last saw the deceased alive on March 30, 1949, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George C. Boyle M. D. Annapolis 3.30.49

23. BURIAL, CREMATION, REMOVAL (Specify) DATE [redacted]-49 NAME OF CEMETERY OR CREMATORY CEDAR BLUFF LOCATION (City, town, or county) (State) ANNAPOLIS MD

DATE REC'D BY LOCAL REG. March 31, 1949

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR ADDRESS JOHN M. TAYLOR & SON - ANNAPOLIS MD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
APR 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02288

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place) 5; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural give location) 39 Paca St

3. NAME OF DECEASED (Type or Print): (First) Cornell (Middle) (Last) Davis

4. DATE OF DEATH: (Month) 3 (Day) 23 (Year) 1949

5. SEX: male

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower

8. DATE OF BIRTH: June 13. 1915

9. AGE last birthday: 33 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Naval Hospital

11. BIRTHPLACE (State or foreign country): Annapolis Neck, R.F.D. Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Davis

14. MOTHER'S MAIDEN NAME: Drucilla Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No; (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Benjamin Davis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Drowning

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Suicide

(c)

975

164 b

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) Suicide; PLACE (Home, farm, factory, street, office, field, etc.) OF INJURY College Creek; (CITY OR TOWN) Annapolis; (COUNTY) Anne Arundel; (STATE) Md

TIME OF INJURY (Month) Mar. (Day) 26 (Year) 1949 (Hour) 10 p.m.; INJURY OCCURRED While at Work ☐ Not While At work ☑

HOW DID INJURY OCCUR? Jumped off bridge into College Creek

22. I hereby certify that I ~~attended the deceased from~~ made a post mortem Examination ~~, 19..., to~~ Mar. 29., 1949., ~~that I last saw the deceased alive on ..., 19...~~, and that death occurred at 10 15 p.m., from the causes and on the date stated above.

SIGNATURE: John M. Caffey (Degree or title) M.D. Deputy Medical Examiner; ADDRESS Annapolis, Md; DATE SIGNED 3/31/49

23. BURIAL, CREMATION, REMOVAL (Specify); DATE 4-4-49; NAME OF CEMETERY OR CREMATORY Annapolis Neck; LOCATION (City, town, or county) Annapolis Neck; (State) Md.

DATE REC'D BY LOCAL REG. April 1, 1949; REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: William Reese, II; ADDRESS 108 Washington St.

RECEIVED
APR 2 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02289

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Curtis Bay | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS ~ 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Cumberstone COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) (Last) DOWNS.
4. DATE OF DEATH: (Month) March (Day) 24 (Year) 1949
5. SEX: FEMALE
6. COLOR OR RACE: COLORED
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOW
8. DATE OF BIRTH: ABT. 1890
9. AGE last birthday: 59 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Cumberstone
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: MOSES BRENT
14. MOTHER'S MAIDEN NAME: Mary Brown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: ✓
17. INFORMANT: Harrison Brent

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral hemmhage.

331 Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis

(c) hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: no | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) Cumberstone (COUNTY) a.a. (STATE) md.

TIME OF INJURY (Month) March (Day) 19 (Year) 49 (Hour) 8:30 P.m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 19, 19 49 to March 24, 19 49, that I last saw the deceased alive on March 23, 19 49, and that death occurred at 6 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Emily H. Wilson, M.D | ADDRESS Lothian, Md. | DATE SIGNED 3/26/49

23. BURIAL, ~~CREMATION~~ Interment (Specify) | DATE MAR. 27-49 | NAME OF CEMETERY ~~OR CREMATORY~~ DANIEL STAR | LOCATION (City, town, or county) WEST RIVER (State) MD.

DATE REC'D BY LOCAL REG. Mar. 28-1949 | REGISTRAR'S SIGNATURE M. Clayton Deputy Reg | 24. FUNERAL DIRECTOR T. A. Stardesty & Son | ADDRESS Galesville Md.

VS. A15

RECEIVED
MAR 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02290

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Emergency Hosptial

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis,
STREET ADDRESS (If rural give location): 147 King George St.

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) S. (Last) Ebeling

4. DATE OF DEATH: (Month) March (Day) 9, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept. 6, 1903

9. AGE last birthday: 45 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Nursing

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William T. Scible

14. MOTHER'S MAIDEN NAME: Agnes G. Tongue

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval between onset and death: 3 days

420.1 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio-Vascular Disease — 10 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1, 1948 to Mar. 9, 1949, that I last saw the deceased alive on 3-9-49, and that death occurred at 7:05 m., from the causes and on the date stated above.

SIGNATURE (Degree or title): James R. Stratton, M.D.

ADDRESS:

DATE SIGNED: 3-11-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 3-12-49

NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery

LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.:

REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: Ben L. Hopping and Son

ADDRESS: Annapolis, Maryland

RECEIVED
MAR 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02291

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Asher's Farm
LENGTH OF STAY (in this place): 3 Mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Spar Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Asher's Farm nr Annapolis,
STREET ADDRESS (If rural give location): Spar Rd

3. NAME OF DECEASED (Type or Print): (First) Dorthey (Middle) (Last) Evans

4. DATE OF DEATH: (Month) (Day) (Year) March 16, 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 4-22-34

9. AGE last birthday: 14 yrs. — If under 1 year: Months 11, Days 14 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Luther Evans

14. MOTHER'S MAIDEN NAME: Rose Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mr. Wesley Peugh Sr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Burns of Entire body (Carbonization)

916.0 Antecedent cause(s)

180 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) House Completely destroyed by fire

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home (CITY OR TOWN): near Annapolis (COUNTY): Anne Arundel (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): March 16 1949 6 A m.
INJURY OCCURRED While at Work ☐ Not While At work ☑
HOW DID INJURY OCCUR? Trapped in burning house

22. I hereby certify that I ~~attended the deceased~~ made Postmortem Examination from ~~.....~~, Mar. 16, 19 49, ~~that I last saw the deceased alive on ....., 19....~~; and that death occurred at 6 20 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): John M. Clatty M.D. Deputy Medical Examiner — ADDRESS: Annapolis Md — DATE SIGNED: 3/16/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 3-17-49 — NAME OF CEMETERY OR CREMATORY: Edward's Chapel — LOCATION (City, town, or county) (State): Riva Rd. Annapolis, Md.

DATE REC'D BY LOCAL REG.: March 17, 1949 — REGISTRAR'S SIGNATURE: W. T. Branch

24. FUNERAL DIRECTOR: Ben L. Hopping and Son — ADDRESS: Annapolis, Maryla

RECEIVED
MAR 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02292

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Baltimore 25
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Baltimore 25
(If outside city or town limits, write RURAL and give nearest town)
Street No. 500 Tanev Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mary Martha Evans

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fem	wh.	

6.(b) Name of husband or wife: Enoch John Evans
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): dead for 4 years 3/9/67

8. AGE:

Years	Months	Days	If less than one day
81	11	28	hrs. min.

9. Birthplace: Grandage Co. W. Va
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER	12. Name: ?
	13. Birthplace: ?
MOTHER	14. Maiden name: Phoebe Taylor
	15. Birthplace: W. Va Randolph Co.

16. Informant: daughter in Laurel
Address 500 Tanev Ave.
17. Removal Date thereof 3/7/49
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Odd Fellows
Location: Elkins, W. Virginia
18. Funeral director: Wm Cook Co
Address 1217 St Paul St
19. 3/7 19 49 A. W. Hesse
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 7 19 49 at 11 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 47 19 to 3 7 19 49 and that I last saw h alive on 3 2 19 49

Immediate cause of death	DURATION
Generalized Carcinomatosis	
Due to: Carcinoma of rectum	3yrs?
Due to: 154	
Other conditions: ulcer	

(Include pregnancy within 3 months of death)

Major findings at operation: Ca of rectum
Date of op 3.10.1944
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Henry L Summers MD
M. D. or other
Address 1015 Reed Ct and Ave Date signed 3.7.49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

02293

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Annapolis Emergency Hospital

City or town Easport, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 3/6/49 – 3/12/49.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County

City or town ~~Annapolis~~
(If outside city or town limits, write RURAL and give nearest town)

Street No. 410 4th St Easport Md
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Morris. Fisher.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	white	single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 56 | Months | Days | If less than one day hrs. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual occupation

11. Industry or business Merchant

FATHER
12. Name Coppel Fisher
13. Birthplace Russia

MOTHER
14. Maiden name Fannie ?
15. Birthplace Russia

16. Informant Mrs Julius Cahn
Address Bishopville S. C

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof March 14, 1949 (month) (day) (year)

Cemetery or crematory Hebrew Herring Run Cemetery

Location Bowleys Lane

18. Funeral director Sol Levinson & Bros
Address 1124-1126 W North Ave

19. 3/14 1949 (Date rec'd by registrar) A. W. Hedrick WB Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1949 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/6/49 19 to 3/12 1949 and that I last saw h. 1M alive on 3/12/49. 19

Immediate cause of death Secondary Hemorrhage. | DURATION

Due to Submucosal hemorrhage and multiple bleeding gastric ulcers.

Due to 540.1 117a

Other conditions Ruptured gastric ulcer

(Include pregnancy within 3 months of death)

Major findings of operations as above

Date of op. 3/6/49.

Autopsy results as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Lowhurst M. D. or other

Address Easport, Md Date signed 3/13/49.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

02294

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville | LENGTH OF STAY (In this place) 15 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY ~~Howard~~ Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville
STREET ADDRESS (If rural, give location) 38 Winters Avenue

3. NAME OF DECEASED (Type or Print): (First) GENEVA (Middle) ELLEN (Last) FOREMAN
4. DATE OF DEATH (Month) (Day) (Year) 3/18/49 19

5. SEX Female
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH ~~unknown~~ Abt 1903
9. AGE last birthday 46(?) yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME George Smith
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) ~~xxxxxxxx~~
16. SOCIAL SECURITY NO. ~~xxxxxxxxxxxxxx~~
17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary embolism, sudden death

155 Antecedent cause(s)

46 f Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cancer of the gall bladder known to us — 3/3/49

(c) Involutional Psychosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ~~xxxxxxxxxx~~
19b. MAJOR FINDINGS OF OPERATION ~~xxxxxxxxxxxxxxxxxxxxxx~~
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) ~~xxxxxxxxxx~~ PLACE OF INJURY (Home, farm, factory, street, office, etc.) ~~xxxxxxxxxxxxxxxxxxxxxx~~ (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ~~xxxxxxxxxxxx~~ m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR? ~~xxxxxxxxxxxx~~

22. I hereby certify that I attended the deceased from 3/3/49, 19....., to 3/18/49, 19....., that I last saw the deceased alive on 3/18/49, 19....., and that death occurred at 5:20 A.M. m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern M.D. (Degree or title) ADDRESS Crownsville, Maryland DATE SIGNED 3/18/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 3/22/49 | NAME OF CEMETERY OR CREMATORY Western Star Cemetary | LOCATION (City, town, or county) (State) Catonsville, Maryland

DATE REC'D BY LOCAL REG. 3/19/49 | REGISTRAR'S SIGNATURE E. Joyce Local Registrar | 24. FUNERAL DIRECTOR Mr Samuel T. Hensley ADDRESS 578 W Biddle St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 22 1949
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02295

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville | LENGTH OF STAY (In this place) 21 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY St. Mary's
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Scotland,
STREET ADDRESS (If rural give location) not known

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) (Last) Gibson
4. DATE OF DEATH: (Month) 3/15/49 (Day) (Year) 19

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married
8. DATE OF BIRTH: 1885 ~~not known~~
9. AGE last birthday: 64(?) yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Not known
14. MOTHER'S MAIDEN NAME: Gussie(?)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Arteriosclerosis — Interval between onset and death: known to us since 2/25/49

450.0 Antecedent cause(s)

97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/25/49, 19....., to 3/15/49, 19....., that I last saw the deceased alive on 3/15/49, 19....., and that death occurred at 10:50 A.m., from the causes and on the date stated above.

SIGNATURE Jacob Thompson M.D (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 3/18/49 | NAME OF CEMETERY OR CREMATORY Crownsville State Hosp | LOCATION (City, town, or county) Crownsville, Md. (State)

DATE REC'D BY LOCAL REG. 3/18-49 | REGISTRAR'S SIGNATURE E. F. Joyce Local Reg | 24. FUNERAL DIRECTOR Supt Hospital | ADDRESS

VS. A15

RECEIVED
MAR 21 1949
BUREAU V. S.

02296

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH· COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland COUNTY AA.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bristol — LENGTH OF STAY (in this place) 79 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bristol
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Joseph Thomas (Middle) Greenwell (Last)

4. DATE OF DEATH (Month) March (Day) 28 (Year) 1949

5. SEX male | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Feb.21,1870 | 9. AGE last birthday 79 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | 10b. KIND OF BUSINESS OR INDUSTRY Farming | 11. BIRTHPLACE (State or foreign country) Galesville,Md | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Joseph L. Greenwell | 14. MOTHER'S MAIDEN NAME Elizabeth Howes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Norman E. Greenwell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypostatic Bronchopneumonia

422.1 Antecedent cause(s)

107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) myocardial failure

(c) arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1949, to March 28, 1949, that I last saw the deceased alive on March 28, 1949, and that death occurred at 3.20 p.m., from the causes and on the date stated above.

SIGNATURE Emily H. Wilson (Degree or title) M.D. ADDRESS Lothian, Md. DATE SIGNED 3/30/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 3/31/49 | NAME OF CEMETERY OR CREMATORY Owensville Catholic | LOCATION (City, town, or county) (State) Owensville, Md

DATE REC'D BY LOCAL REG. 3/31/49 | REGISTRAR'S SIGNATURE [signature] Deg Hand | 24. FUNERAL DIRECTOR T.A.Hardesty & Son ADDRESS Galesville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02297

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Pasadena, Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, Institution, or street address where death occurred: Lake Shore Drive - Pasadena, Md

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural — (If outside city or town limits, write RURAL and give nearest town)

Street No.: Lake Shore Drive - Pasadena, Md (If rural, give LOCATION)

2.(a) If veteran, name war: None —

3.(a) FULL NAME: George Anton Heiderick

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married.

6.(b) Name of husband or wife: Beulah Heiderick

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): July 4, 1861

8. AGE: Years	Months	Days	If less than one day
87	8	0	0 hrs. — min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming.

FATHER — 12. Name: George Anton Heiderick

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Sarah Rupp

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs G.A. Heiderick

Address: Lake Shore Drive - Pasadena Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/7/49 (month) (day) (year)

Cemetery or crematory: Balto Cemetery

Location: Balto.

18. Funeral director: Wm Cook Inc.

Address: 1217 N Paul St.

19. 3-7 (Date rec'd by registrar) 19 49 D.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 1949 at 8:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1948 to March 4 1949 and that I last saw h.. alive on March 4 1949

Immediate cause of death	DURATION
Myocardial failure -	3-4 yrs
Probable malignancy of	2 yrs?
Sigmoid colon.	
Due to Chronic Degenerative	3-4 yrs
Myocarditis	
Due to Generalized & coronary	Indefinite
sclerosis.	
Other conditions Encephalopathy -	1 month.
due to cerebral thrombosis -	

(Include pregnancy within 3 months of death)

153 III

Major findings of operations: None — Date of op. —

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: O.T. Gadoua M.D. M. D. or other

Address: Green Gables · Pasadena, Md Date signed: Mar. 4 1949

02298

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: A.A.

City or town: Solley
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Solley
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Stoney Creek Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ANNA HENKEL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: John W.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): I/2/I87I

8. AGE:

Years	Months	Days	If less than one day
78	2	5	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife - retired

11. Industry or business

FATHER
12. Name: Henry Winkler
13. Birthplace: Md.

MOTHER
14. Maiden name: Johanna Patrie
15. Birthplace: Md.

16. Informant: Family
Address: Same

17. B (Burial, cremation, or removal. Which?) Date thereof: 3/2I/49 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md.

18. Funeral director: [signature]

Address: I30 East Fort Avenue

19. 3/21 1949 [signature] Registrar
(registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1949 at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946, to March 17 1949 and that I last saw h ER alive on March 14 1949

Immediate cause of death	DURATION
Heart Failure	
Due to Cerebral Hemmorrhage	1 month
Due to Hypertensive Cardio-Vascular Disease	10 years
Other conditions 443 93d Arteriosclerosis	10 years

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: J. Brady Smith, M.D.
M. D. or other

Address: Riviera Beach, Md. Date signed: 3/18/49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

02299

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ft Geo G. Meade — LENGTH OF STAY (in this place) 6 days
   HOSPITAL OR INSTITUTION OR STREET ADDRESS Station Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Louisiana — COUNTY Orleans
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Orleans
   STREET ADDRESS (If rural give location) 425 Bermuda Street

3. NAME OF DECEASED (Type or Print): (First) MICHAEL (Middle) NMI (Last) HENRICKS

4. DATE OF DEATH: (Month) March (Day) 3 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): —

8. DATE OF BIRTH: 25 Feb 1949

9. AGE last birthday: yrs. — If under 1 year: Months — Days 8 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): — —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): — —

12. CITIZEN OF WHAT COUNTRY? — —

13. FATHER'S NAME: Albert Michael Henricks

14. MOTHER'S MAIDEN NAME: Dorothy May Prantgos

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) — —

16. SOCIAL SECURITY NO. — —

17. INFORMANT: Albert Michael Henricks

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Malnutrition

772.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Inability to digest food

159 (c) Premature birth, 6 months gestation.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION — — — 19b. MAJOR FINDINGS OF OPERATION — — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE) — —

TIME OF INJURY (Month) — (Day) — (Year) — (Hour) — m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR? — — — — — —

22. I hereby certify that I attended the deceased from 25 Feb, 1949, to 3 Mar, 1949, that I last saw the deceased alive on 3 Mar, 1949, and that death occurred at 7:59 A m., from the causes and on the date stated above.

SIGNATURE Henry M. Foster — (Degree or title) CAPT., MC — ADDRESS Ft Geo G. Meade, Md. — DATE SIGNED 10 Mar 1949

HENRY M. FOSTER

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF 3 Mar 49 — NAME OF CEMETERY OR CREMATORY Post Cemetery — LOCATION (City, town, or county) (State) Ft George G. Meade, Md.

DATE REC'D BY LOCAL REG. 10 Mar 49 — REGISTRAR'S SIGNATURE E. K. BURNSIDE, CAPT MSC

24. FUNERAL DIRECTOR — ADDRESS Capt J. T. Hayes (Chap) Ft Meade, Md.

RECEIVED
MAR 12 1949
BUREAU V. S.

02300

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place) Dead on arrival
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Isaac; (Middle) David; (Last) Hill

4. DATE OF DEATH: (Month) 3; (Day) 19; (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 2-15-1949

9. AGE last birthday: yrs. If under 1 year: Months. 1; Days 2; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Annapolis, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Scoggins

14. MOTHER'S MAIDEN NAME: Mary Estes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mary Hill

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Asphyxiation

924.0 Antecedent cause(s)

182 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): at home
(CITY OR TOWN): Parole (COUNTY): Anne Arundel (STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): Mar. 19 1949 9 A.m.
INJURY OCCURRED While at Work ☒ Not While At work ☐
HOW DID INJURY OCCUR? was asleep in bed with mother

22. I hereby certify that I ~~attended the deceased from~~ Postmortem Examination, 19..., to Mar. 19, 1949, ~~that I last saw the deceased alive on~~ ..., 19..., and that death occurred at 9-15 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John N. Caffey, M.D., Deputy Medical Examiner Annapolis Md Mar. 22, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 3-22-1949
NAME OF CEMETERY OR CREMATORY: Asbury
LOCATION (City, town, or county) (State): Smithville, Md.

DATE REC'D BY LOCAL REG.: March 22, 1949
REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: William Reese, II
ADDRESS: Annapolis, Md.

RECEIVED
MAR 23 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

23195

1. PLACE OF DEATH: COUNTY Anne Arundel Co. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (In this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7 Calvert Court	STREET ADDRESS (If rural, give location) 7 Calvert Court

3. NAME OF DECEASED (Type or Print) (First) Mary	(Middle) Ester	(Last) Larkins	4. DATE OF DEATH (Month) 3	(Day) 20	(Year) 1949
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 3/30/1902	9. AGE last birthday 46 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Anne Arundel Co. Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Frances Tilghman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 216-16-4426	17. INFORMANT Mentheola Jones			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Apoplesxyy

443 Antecedent cause(s) Hypertensive Cardio Vascular Disease — 2 days

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — 2 days

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. No

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION None — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) No — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-16-49, 19....., to 3-20-49, 19....., that I last saw the deceased alive on 3-20-49, 19....., and that death occurred at 12:30A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Theodore S. Johnson M.D. — ADDRESS 40 Northwest Street Annapolis, Md — DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 3/23/1949	NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery	LOCATION (City, town, or county) (State) West St. Annapolis, Md.
DATE REC'D BY LOCAL REG. March 22, 1949	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Mrs. Charles E. Hicks	ADDRESS 43-45 Northwest St.

RECEIVED
MAR 23 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12301

not BC

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brooklyn Station R-1-D (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 432 N. Bradd St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Emma Manley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Colored.	Married.

6.(b) Name of husband or wife: John Manley

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): ? Abt. 1895

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
54	?	?		

9. Birthplace: Salisbury - N. C. (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: ?

FATHER — 12. Name: ?

13. Birthplace: ?

MOTHER — 14. Maiden name: ?

15. Birthplace: ?

16. Informant: John Manley (Husband) Address: Brother-in-law - P.O. Brooklyn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/21/49 (month) (day) (year)

Cemetery or crematory:

Location: High Point N. C.

18. Funeral director: Metropolitan Funeral Home Inc.

Address: 927 N. Mount St.

19. 3/18/49 (Date rec'd by registrar) Registrar: A.W. Seduck

32

MEDICAL CERTIFICATION

20. DATE OF DEATH: March - 16 19 49, at 10 30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—, to ——— 19—

and that I last saw h— alive on ——— 19—

Immediate cause of death: Coronary Occlusion — DURATION: Hrs.

Due to:

Due to: 420.1 / 440

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. N. Paulen M.D. M. D. or other

Address: Baltimore Md. Date signed: 3/17/49

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1900
54
1955

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02302

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15.

1. PLACE OF DEATH: COUNTY Anne Arundel County MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 10 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balti. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1525 E. Fayette Street

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) (Last) Massey
4. DATE OF DEATH: (Month) 3/22/49 (Day) (Year) 19

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 1/22/88
9. AGE last birthday: 61 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frank Massey
14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Paresis — Interval between onset and death: known to us since 5/22/48

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/22/48, 19....., to 3/22/49, 19....., that I last saw the deceased alive on 3/22/49, 19....., and that death occurred at 10:33 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Carl Augenstein M.D.
ADDRESS Crownsville, Maryland
DATE SIGNED 3/23/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE 4/1/49
NAME OF CEMETERY OR CREMATORY Crownsville State Hosp.
LOCATION (City, town, or county) (State) Crownsville, Md.

DATE RECD BY LOCAL REG. 4/1.49
REGISTRAR'S SIGNATURE E.F. Joyce L. Reg.
24. FUNERAL DIRECTOR Supt Hospital
ADDRESS Crownsville Md

RECEIVED
APR 4 1949
BUREAU V. S.

02303

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Orchard Beach — LENGTH OF STAY (In this place) 25 y's
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Orchard Beach
STREET ADDRESS (If rural give location) Chesapeake Drive Orchard Beach

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Elizabeth (Last) Matthews

4. DATE OF DEATH: (Month) March (Day) 16 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov. 6, 1869

9. AGE last birthday: 79 yrs. — If under 1 year: Months 4 Days 10 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles (?) Sanford

14. MOTHER'S MAIDEN NAME: Anna Sanford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Henry Fey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Odema — 3 d's.

422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d (b) Chronic Myocarditis — 2 yrs.

(c) Generalized arteriosclerosis — (?)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diplegia - legs — 8 mos.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 1947, to March 16, 1949, that I last saw the deceased alive on March 14, 1949, and that death occurred at 10:25 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Isadore Kaplan M.D. 2918 Allendale Rd. Balto. 16, Md. 3-17-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF Mar 19 1949 — NAME OF CEMETERY OR CREMATORY Mt Carmel Cem — LOCATION (City, town, or county) Baltimore — (State)

DATE REC'D BY LOCAL REG. 3-18-49 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR Philip Herwig Sons — ADDRESS Eutaw St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02304

CERTIFICATE OF DEATH

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater — LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater
STREET ADDRESS (If rural, give location) Woodland Beach

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (Last) McCauliffe
4. DATE OF DEATH: (Month) March (Day) 16, (Year) 1949.
5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan. 23 1877
9. AGE last birthday: 72 yrs. If under 1 year: Months 2, Days 21, Hours, Min. If under 24 hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Insulator
11. BIRTHPLACE (State or foreign country): Schenectady New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: not known
14. MOTHER'S MAIDEN NAME: not known
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No
16. SOCIAL SECURITY NO.: - - -
17. INFORMANT: Mrs Sarah McCauliff

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Cardiac Failure — sudden

442 Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Cardio-renal vascular disease — unknown
131a (c) General Arterio-sclerosis — 15 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended the deceased from~~ made Postmortem Examination, Mar. 16, 1949, ~~that I last saw the deceased alive on ..., 19--~~, and that death occurred at 10:00 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
John M. Caffey M.D. Deputy Medical Examiner — Annapolis, Maryland — 3/16/49

23. BURIAL, CREMATION OR REMOVAL (Specify): Burial — DATE: 3/19/49 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State): Washington D.C.

DATE REC'D BY LOCAL REG. 3/16/49 — REGISTRAR'S SIGNATURE: D.M. Clayton Registrar — 24. FUNERAL DIRECTOR: W W Chambers Co — ADDRESS: 517-11th St SE Washington, D.C.

RECEIVED
MAR 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02305

CERTIFICATE OF DEATH

Reg. Dist. No. L4747

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Pumphrey
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Pumphrey
(If outside city or town limits, write RURAL and give nearest town)

Street No. 242 Zeppelin Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Susan Ann McKim

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	C	W.

6.(b) Name of husband or wife: Samuel McKim

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 13 1894

8. AGE:

Years	Months	Days	If less than one day
54	3	27	..... hrs. ..... min.

8. Birthplace: Ivy, Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Gross
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Agnes Disper
15. Birthplace: Sussex Co. Virginia

16. Informant: Beulah McClaine

Address: 437 Sevale Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 17 49 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Anne Arundel Co.

18. Funeral director: Mrs Samuel T Hemsley

Address: 578 W Biddle St.

19. 3/14 1949 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1949, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 1948, to March 10 1949, and that I last saw her alive on March 10 1949

Immediate cause of death: Coronary Thrombosis

Due to: Arterio-sclerotic Heart Disease

Due to: 420.0 934

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Renold B Livingston M. D. ~~Coroner~~

Address: 501 Cherry Hill Road Date signed 3-12-49

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02306

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Margate (Brooklyn25) LENGTH OF STAY (In this place) 11 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Margate (Brooklyn 25 Md.)
STREET ADDRESS (If rural give location) Margate Drive

3. NAME OF DECEASED (Type or Print) (First) Frederick O. (Middle) Michael (Last)

4. DATE OF DEATH (Month) March (Day) 26 (Year) 1949

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH Marcg 5,1869 | 9. AGE last birthday 80 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (retired) | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | 11. BIRTHPLACE (State or foreign country) Firm Rock Garrett Co, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Jackson Michael | 14. MOTHER'S MAIDEN NAME Mary Shaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY No. None | 17. INFORMANT Mrs. James R. Spiker Margate Brooklyn 25, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) UREMIA	1 WK
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) CONGESTIVE HEART FAILURE	3 MONTHS
	(c) ARTERIOSCLEROTIC HEAT DISEASE	4 MONTHS

420.0
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. NONE

19a. DATE OF OPERATION NONE | 19b. MAJOR FINDINGS OF OPERATION NONE | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) NONE | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1948, to Mar, 1949, that I last saw the deceased alive on Mar 25, 1949, and that death occurred at 7.20P. m., from the causes and on the date stated above.

SIGNATURE Henry F. Zingara MD (Degree or title) ADDRESS Glen Burnie DATE SIGNED 3/28/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE March 30 1949 | NAME OF CEMETERY OR CREMATORY Laurel Hill | LOCATION (City, town, or county) Lonaconing (State) Md.

DATE REC'D BY LOCAL REG. 3/28/49 | REGISTRAR'S SIGNATURE L. J. DeAlba | 24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS Glen Burnie, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 30 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02307

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 3 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 3 St. John's Street

3. NAME OF DECEASED (Type or Print): (First) STEPHEN (Middle) (Last) MOORE

4. DATE OF DEATH: (Month) March (Day) 26 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Dec 27,48

9. AGE last birthday: 0 yrs. If under 1 year: Months 3; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Chester G. Moore

14. MOTHER'S MAIDEN NAME: Mildred E. Leahy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Chester G. Moore

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Subt. dural Hemorrhage on right side — Interval Between Onset and Death: sudden

331 Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) unknown.

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Premature birth.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination, 19..., to Mar. 26 1949, ~~that I last saw the deceased alive on ..., 19...~~; and that death occurred at 11 30 A. m., from the causes and on the date stated above.

SIGNATURE: John M. Claffy M.D. (Degree or title) Deputy medical Examiner ADDRESS: Annapolis Md DATE SIGNED: 3/26/49.

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: March 27,49

NAME OF CEMETERY OR CREMATORY: St Mary's Cemetery

LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Mar. 26,1949

REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: Ben L. Hopping and Son ADDRESS: Annapolis, Md.

VS-A15

RECEIVED
MAR 29 1949
BUREAU T. S

02308

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Round Bay
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Round Bay
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) NORMAN (Middle) BAILEY (Last) MORROW
4. DATE OF DEATH (Month) 3 (Day) 7 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 6/21/1897
9. AGE last birthday 51 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Real Estate
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Minor E. Morrow
14. MOTHER'S MAIDEN NAME Mary Moore
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT William B. Morrow

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Suicide	
976 Antecedent cause(s)	(b)	Bullet-wound in head.	
164c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	Melancholia	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home
(CITY OR TOWN) Round Bay (COUNTY) Severna Park (STATE) A.A., Maryland
TIME OF INJURY (Month) (Day) (Year) (Hour) Mar. 7 1949 2:35 p.m.
INJURY OCCURRED While at Work ☐ Not While At work ☑
HOW DID INJURY OCCUR? Self inflicted .38 cal. bullet wound

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination, 19..., to Mar 7, 1949, ~~that I last saw the deceased alive on~~ ..., 19..., and that death occurred at 2:35 p.m., from the causes and on the date stated above.

SIGNATURE John M. Klaffy M.D., Deputy Medical Examiner (Degree or title) ADDRESS Annapolis Md. DATE SIGNED 3-8-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE 3/9/49 NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park LOCATION (City, town, or county) Glen Burnie (State) Md.

DATE REC'D BY LOCAL REG. March 9, 1949 REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor-Son ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 10 1949
BUREAU V. S.

Dr. Klavans.

02309

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: Anne Arundel | MARYLAND | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severna Park | LENGTH OF STAY (in this place) | HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland | COUNTY: Anne Arundel | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severna Park | STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Isaiah (Middle) [illegible] (Last) Pack

4. DATE OF DEATH: (Month) March (Day) 3 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: June 20 1873

9. AGE last birthday: 75 yrs. | If under 1 year: Months 8 Days 17 | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Jutson Pack

14. MOTHER'S MAIDEN NAME: Rebecca Pack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: James Pack

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of lung — Interval Between Onset and Death: 6-12 mos.

163 Antecedent cause(s)

472 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Frequent x rays, brought forth Cancerous, as above

19a. DATE OF OPERATION: None | 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept ....., 19 48., to March 3 ....., 19 49., that I last saw the deceased alive on Feb 28 ....., 19 49, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Manuel J. Klavans MD | ADDRESS: Annapolis, Md | DATE SIGNED: 3/5/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: March 6 1949 | NAME OF CEMETERY OR CREMATORY: Jonesville | LOCATION (City, town, or county) (State): Severna Park Md

DATE REC'D BY LOCAL REG.: March 6, 1949 | REGISTRAR'S SIGNATURE: [illegible] | 24. FUNERAL DIRECTOR: J.B. Johnson | ADDRESS: Annapolis Md.

VS. A15

RECEIVED
1949
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02310

Reg. Dist. No. 28

1. PLACE OF DEATH COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Balt. City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — LENGTH OF STAY (in this place): 9 mos. 1 day	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): Patapsco Avenue (number unknown)

3. NAME OF DECEASED (Type or Print)	(First) Maria	(Middle) Casey	(Last) Paige	4. DATE OF DEATH	(Month) 3/	(Day) 1/ (Year) 1949
5. SEX: female	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: 1893	9. AGE last birthday: 56 yrs.	If under 1 year Months Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME: James Herns	14. MOTHER'S MAIDEN NAME: Nancy Green					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinoma Ventriculi	known to us
151 Antecedent cause(s)		since 1/18/49
46b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Senile Psychosis	known since 5/28/48

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While at Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/28/48, 19....., to 3/1/49, 19....., that I last saw the deceased alive on 3/1/49, 19....., and that death occurred at 1:15 A.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville, Maryland	3/1/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 3-4-49	NAME OF CEMETERY OR CREMATORY: Mt. Auburn Am.	LOCATION (City, town, or county) (State): Balto. Md
DATE REC'D BY LOCAL REG.: 3-2-49	REGISTRAR'S SIGNATURE: A. W. Hedick	24. FUNERAL DIRECTOR: Mrs Katie R. Williams	ADDRESS: 322 N Schroeder St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

02311

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Ann Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Asher's Farm — LENGTH OF STAY (in this place) 3 Mo.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Asher's Farm nr Annapolis, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spa Rd.	STREET ADDRESS (If rural give location) Spa Rd.

3. NAME OF DECEASED (Type or Print) (First) Joan Craford (Middle) Peugh (Last)

4. DATE OF DEATH (Month) (Day) (Year) March 16, 1949 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Female	White	Single	2-24-1940	9 yrs.	0	12		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wesley Peugh Sr.	~~Gladys Evans~~ Margaret Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no		none	Mr. Wesley Peugh Sr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Burns of Entire body (carbonization)

916.0 Antecedent cause(s)

180 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) House Completely destroyed by fire

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) accident — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home — (CITY OR TOWN) near Annapolis — (COUNTY) Anne Arundel — (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) Mar. 16, 1949 6 A.m. — INJURY OCCURRED While at Work ☐ Not While At work ☑ — HOW DID INJURY OCCUR? Trapped in burning house

22. I hereby certify that I ~~attended the deceased from~~ ....., 19...., ~~to~~ Mar. 16, 1949, ~~that I last saw the deceased alive on~~ ....., 19...., and that death occurred at 6:20 A.m., from the causes and on the date stated above.

SIGNATURE John M. Claffey, M.D., (Degree or title) Deputy Medical Examiner — ADDRESS Annapolis Md. — DATE SIGNED 3/16/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3-17-49	Edward's Chapel	Riva Rd. Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 17, 1949	[signature]	B. L. Hopping and Son	Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
MAR 18 1949
BUREAU V. S.

02312

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Asher's Farm
LENGTH OF STAY (in this place) 3 Mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spar Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Asher's Farm nr Annapolis,
STREET ADDRESS (If rural give location) Spar Rd.

3. NAME OF DECEASED (Type or Print) (First) Wesley (Middle) (Last) Peugh Jr.
4. DATE OF DEATH (Month) (Day) (Year) March 16, 1949 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH July 22, 1941
9. AGE last birthday 7 yrs. If under 1 year Months 7 Days 14 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wesley Peugh Sr.
14. MOTHER'S MAIDEN NAME ~~Gladys Evans~~ Margaret Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mr. Wesley Peugh Sr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Burns of Entire body (carbonization)

916.0 Antecedent cause(s)

180 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) House Completely destroyed by fire

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) accident —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home (CITY OR TOWN) near Annapolis (COUNTY) Anne Arundel (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) Mar 16, 1949 6 A.m.
INJURY OCCURRED While at Work ☐ Not While At work ☑
HOW DID INJURY OCCUR? Trapped in burning house

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination, ~~19~~, ~~to~~ Mar. 16, 1949, ~~that I last saw the deceased alive on~~, ~~19~~, and that death occurred at 6 20 A m., from the causes and on the date stated above.

SIGNATURE John M. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 3/16/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE 3-17-49
NAME OF CEMETERY OR CREMATORY Edward's Chapel
LOCATION (City, town, or county) (State) Riva Rd. Annapolis, Md.

DATE REC'D BY LOCAL REG. March 17, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 18 1949
BUREAU V. S.

02313

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN near Jacobsville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Jacobsville

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jacobsville (Pasadena Md. P.O.)
STREET ADDRESS (If rural, give location) MOUNTAIN ROAD.

3. NAME OF DECEASED (Type or Print) (First) Thomas (Middle) J. (Last) Phelps

4. DATE OF DEATH (Month) Mar. (Day) 23 (Year) 1949

5. SEX male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH ~~UNKNOWN~~ ABT. 1880
9. AGE last birthday About 69 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION. (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) ODENTON, A.A. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME Jim. Phelps
14. MOTHER'S MAIDEN NAME Martha Mewsaw.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. NONE.
17. INFORMANT Grover C. Phelps.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Coronary occlusion	sudden
420.1 Antecedent cause(s)			
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Coronary sclerosis	unknown
	(c)	General arterio-sclerosis	unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination ~~, 19~~ to Mar. 23, 1949, ~~that I last saw the deceased alive on~~ ~~, 19~~, and that death occurred at 6 P. m., from the causes and on the date stated above.

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md DATE SIGNED 3/23/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE March 27, 1949
NAME OF CEMETERY OR CREMATORY Privale-(Phelps)
LOCATION (City, town, or county) (State) Farm of James Phelps, Severn, Md.

DATE REC'D BY LOCAL REG. 3/26/49
REGISTRAR'S SIGNATURE L. J. Dr Alba
24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS, ...

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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1949

RECEIVED
MAR 28 1949
BUREAU V. S.

02314

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eastport
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 807 Severn Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: A. A. Co.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eastport
STREET ADDRESS (If rural, give location): 807 Severn Ave.

3. NAME OF DECEASED (Type or Print) (First) EDITH (Middle) S. (Last) PILGRIM

4. DATE OF DEATH (Month) 3 (Day) 3 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: White
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED,~~ (Specify)
8. DATE OF BIRTH: 12/12/1868
9. AGE last birthday: 80 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ENGLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Horace Dean

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 hours.

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis generalized

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to March 3 1949, that I last saw the deceased alive on Mar 3, 1949, and that death occurred at 7:45 A.m., from the causes and on the date stated above.

SIGNATURE: E Lin Laidt — (Degree or title): MD — ADDRESS: Eastport Md — DATE SIGNED: 3/4/49

23. BURIAL, ~~CREMATION REMOVAL~~ (Specify) — DATE: 3/5/49 — NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery — LOCATION (City, town, or county) (State): Prince Georges Co. Md.

DATE REC'D BY LOCAL REG.: March 4, 1949 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: John M. Taylor Son — ADDRESS: Annapolis Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02315

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 1404 West Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A. Co.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.; STREET ADDRESS (If rural, give location) 1404 West Street

3. NAME OF DECEASED (Type or Print): (First) ARTHUR (Middle) LEE (Last) POORE

4. DATE OF DEATH: (Month) 3 (Day) 9 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 6/7/1895

9. AGE last birthday: 53 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mgr. Southern Dairies

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Poore

14. MOTHER'S MAIDEN NAME: Mary Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If year, give war or dates of service) unknown

16. SOCIAL SECURITY NO. —

17. INFORMANT: Mrs. Lydia K. Poore

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Dilatation of Heart — Interval between onset and death: Sudden

443 Antecedent cause(s)

932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic Myocarditis — about 1 yr

(c) Chronic Rheumatismal Nephritis — Several months

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Long Standing Arterial Hypertension — about 8 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 3, 1948, to March 9, 1949, that I last saw the deceased alive on March 9, 1949, and that death occurred at 10:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Oliver Purvis M.D. Annapolis Md 3/10/49

23. BURIAL, CREMATION ~~REMOVAL~~ (Specify) DATE 3/12/1949 NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem. LOCATION (City, town, or county) (State) Prince George Co. Md.

DATE REC'D BY LOCAL REG. March 10, 1949

REGISTRAR'S SIGNATURE J. A. Branch

24. FUNERAL DIRECTOR ADDRESS John M. Taylor Son Annapolis, Maryland.

VS. A15

RECEIVED
MAR 11 1949
BUREAU OF STANDARDS
RECEIVED
MAR 11 1949
U. S.

02316

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (In this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mayo
STREET ADDRESS (If rural, give location): Edgewater Post Office

3. NAME OF DECEASED (Type or Print): (First) Adie (Middle) Virginia (Last) Popham

4. DATE OF DEATH: (Month) March (Day) 3, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Feb. 15, 1878

9. AGE last birthday: 71 yrs. — If under 1 year: Months: 0, Days: 18 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mayo, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard F. Ball

14. MOTHER'S MAIDEN NAME: Alice V. Machett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mr. Richard F. Popham

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	Sudden
420.1 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Sclerosis & Chr. Myocarditis	Several years
	(c) Chronic Gall Bladder Disease	10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 26, 1949, to March 3, 1949, that I last saw the deceased alive on March 3, 1949, and that death occurred at 5 P m., from the causes and on the date stated above.

SIGNATURE: George C. Basil (Degree or title): M. D. ADDRESS: Annapolis Md DATE SIGNED: 3-5-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: March 6, 1949 — NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery — LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: March 5, 1949 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR — ADDRESS: Ben L. Hopping and Son Annapolis, Md.

VS. A15

RECEIVED
MAR 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02317

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel County — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville | LENGTH OF STAY (In this place) 33 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) Unknown

3. NAME OF DECEASED (Type or Print)	(First) SALLIE	(Middle)	(Last) PORTER	4. DATE OF DEATH (Month) 3	(Day) 22	(Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
fem.	colored	Married	~~Unknown~~ Abt. 1879	70 yrs.	?	?	?	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
domestic			

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no			Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
153 Immediate cause	(a) Cancer of the Sigmoid with liver-meatstases	8 ms
46 2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Dementia precox - catatonic type	34 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
----	----	----	----	----

TIME OF INJURY (Month) (Day) (Year) (Hour)	m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/29/15, 19....., to 3/22/49, 19....., that I last saw the deceased alive on 3/22/49, 19....., and that death occurred at 11 PM m., from the causes and on the date stated above.

SIGNATURE Jacob Marcuster M.D. (Degree or title) ADDRESS DATE SIGNED 3/22/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/26 49	Hospital	Crownsville Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3/25/49	E. T. Joyce Local Reg	Dept. Hospital	Crownsville Md

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RECEIVED
MAR 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02318

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 247 Meadow Road
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME: Mabel I. Prenger

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: John T. Prenger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 12 - 1899

8. AGE: Years: 49 Months: 4 Days: 19 If less than one day ..... hrs. ..... min.

9. Birthplace: Sparrows Point Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William S. Little
13. Birthplace: Balto. Md.

MOTHER
14. Maiden name: Edith Trocker
15. Birthplace: Baltimore Md.

16. Informant: John T. Prenger
Address: 247 Meadow Rd.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 4-4-1949 (month) (day) (year)

Cemetery or crematory: Balto. National

Location .....

18. Funeral director: Flynn & Fleming
Address: 1426 Light St.

19. April 2nd 1949 (Date rec'd by registrar) R.W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 - 1949 at 11:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1947 to 3/31 1949 and that I last saw her alive on 3/29/49 19

Immediate cause of death: Coronary occlusion

Due to: Hypertension
Arthritis

Due to: Gall bladder disease

Other conditions: 420.1 94a (Include pregnancy within 3 months of death)

DURATION

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Samuel Rubin M.D. M. D. or other

Address: 203 Patapsco Ave. Date signed: 4/1/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02319

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS MD
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS EMERGENCY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN EASTPORT
STREET ADDRESS (If rural, give location) 608 BAY RIDGE AVE

3. NAME OF DECEASED (Type or Print) (First) MABEL (Middle) HOWARD (Last) REVELLE

4. DATE OF DEATH (Month) 3 (Day) 13 (Year) 1949

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 3-20-1887
9. AGE last birthday 61 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) BALTIMORE MD
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME HARRY STARR
14. MOTHER'S MAIDEN NAME LAURA BATEMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT CHARLE H. REVELLE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocarditis. Ch. with Myocardial Insufficiency	3 years
Antecedent cause(s)	(b) Generalized Arteriosclerosis	3 years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Cholecystitis	2 years

422.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1, 1949, to March 13, 1949, that I last saw the deceased alive on March 13, 1949, and that death occurred at 2 P m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 3-15-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE 3-16-49 NAME OF CEMETERY OR CREMATORY EDWARDS CHAPEL LOCATION (City, town, or county) PAROLE (State) MD

DATE REC'D BY LOCAL REG. 3/15/49 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR JOHN M. TAYLOR & SON ADDRESS ANNAPOLIS MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02320

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A. A. County, Md.

City or town Patapsco Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A. Co. Md.

City or town Patapsco Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 315 Zeppelin Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Joseph Richardson.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	married

6.(b) Name of husband or wife Sarah Richardson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 20, 1882

8. AGE: Years	Months	Days	If less than one day
66			..... hrs. ..... min.

9. Birthplace Petersburg Virginia

(Town, county, and state)

10. Usual occupation Plaster

11. Industry or business

FATHER 12. Name Joseph Richardson

13. Birthplace Virginia

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Joseph Ed. Smith

Address 320 Zeppelin Ave

17. Burial Date thereof 3-25-49

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory W. H. Auburn Cem.

Location Baltimore Md.

18. Funeral director Mrs. Katie R. Williams

Address 822 N. Schroeder St.

19. 3/26/49 Dee Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1949 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1940 to Mar. 25 1949

and that I last saw him alive on March 25 1949

Immediate cause of death	DURATION
Cardio-vascular disease	3 yrs.
422.1	
Due to 93d	
Due to Prostatic Enlargement	4 days
Other conditions & Acute Retention	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Bacon, M.D. M. D. or other

Address Littlestown Date signed 3/23/49

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

02321

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A A Co.
City or town Orchard Beach
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A A Co Md
City or town Orchard Beach Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Agnes Rodenbaugh

3. (b) Social Security Number

4. Sex F
5. Color or race White
6. (a) Single, married, widowed, or divorced Widowed
8 (b) Name of husband or wife William J.
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-5-1878 ?
8. AGE: Years 71 Months 1 Days 18 If less than one day hrs. min.
9. Birthplace Phila Pa (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Harry Steyerwald
13. Birthplace Pa.
MOTHER 14. Maiden name Caroline —
15. Birthplace Pa
16. Informant William J Rodenbaugh
Address Orchard Beach A A Co Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 25 1949 (month) (day) (year)
Cemetery or crematory Mt Olivet
Location Frederick Rd
18. Funeral director Edward Foulson
Address 2359 Wash Blvd Balto Md
19. 3/24 1949 (Date rec'd by registrar) A L Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1949, at 2:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1949, to March 23 1949, and that I last saw her alive on March 22 1949.
Immediate cause of death Heart Failure
Due to Carcinoma Breast Generalized Metastases
Due to
Other conditions
170
50 (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION
6 months

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Brady Smith M.D. M. D. or other
Address Riviera Beach, Md. Date signed 3/23/49

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02322

Reg. Diat. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Katie L Scott

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Clarence E
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 16, 1878

8. AGE: Years: 70 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: N. Carolina (Town, county, and state)
10. Usual occupation: Home - wife
11. Industry or business

FATHER
12. Name: Marion A Clifton
13. Birthplace: N. Carolina

MOTHER
14. Maiden name: Margaret Jernigan
15. Birthplace: N. Carolina

16. Informant: Clarence E Scott
Address: Deale, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mch 13, 1949 (month) (day) (year)
Cemetery or crematory: Congressional
Location: Washington D C
18. Funeral director: Robert A Mattingly
Address: 131-11th St S E Washington D.C.
19. Mch 10th 49 (Date rec'd by registrar) H. L. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 Mar 1949, at 5:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947, to 10 Mar 1949 and that I last saw h.e.r. alive on 9 Mar 1949

	DURATION
Immediate cause of death: Congestive Heart Failure	2 yrs
Due to: Hypertension c v disease	
Due to: 443 932	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert B Lamar M. D. ~~or other~~
Address: Upper Marlboro Md Date signed: 10 Mar 49

RECEIVED
MAR 11 1949
BUREAU Y. S.

02323

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 1 Mo. 24 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Prince Geo.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Upper Marlboro
STREET ADDRESS (If rural, give location): R.F.D. #1

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Wesley (Last) Sellman
4. DATE OF DEATH: (Month) 3/ (Day) 31/ (Year) 1949
5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowerer
8. DATE OF BIRTH: not known
9. AGE last birthday: 90(?) yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Sellman
14. MOTHER'S MAIDEN NAME: Rachel Sellman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 Immediate cause (a) General Arteriosclerosis

97 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: known to us since 2/7/49

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/7/49, 19....., to 3/31/49, 19....., that I last saw the deceased alive on 3/31/49, 19....., and that death occurred at 1:15 P.M. m., from the causes and on the date stated above.

SIGNATURE: Jacob Morgenstern M.D. (Degree or title)
ADDRESS: Crownsville State Hospital, Md.
DATE SIGNED: 3/31/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: Apr. 3/49
NAME OF CEMETERY OR CREMATORY: Union Cem.
LOCATION (City, town, or county) (State): Bristol, Md.

DATE REC'D BY LOCAL REG.: April 1, 1949
REGISTRAR'S SIGNATURE: E. F. Joyce Local Reg.
24. FUNERAL DIRECTOR: Annie A. Johnson
ADDRESS: Annapolis

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
APR 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02324

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dorsey Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole
STREET ADDRESS (If rural, give location) Dorsey Ave

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Charles	Moses	Smith	3	21	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Male	Negro	Married	5-3-1871	77 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	U.S.N.A.	Friendship, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Smith	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Mrs. Margaret Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac Failure

Antecedent cause(s) (b) Hypertensive Cardio Vascular — 2 days

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 3-20-49, 19....., to 3-21-49, 19....., that I last saw the deceased alive on 3-21-49, 19....., and that death occurred at 12:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Dr Theodore H. Johnson,	40 Northwest St. Annapolis, Md.	

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3-24-1949	Brewer Hill	Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 23, 1949		William Reese	Annapolis, Md.

RECEIVED
MAR 24 1949
BUREAU V. S.

02325

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundle County

City or town: ~~Baltimore~~ (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, institution, or street address where death occurred: 200 5th Ave. Brooklyn Park

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundle

City or town: ~~Baltimore~~ (If outside city or town limits, write RURAL and give nearest town)

Street No. 200 5th Ave. Brooklyn Park (If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: George Smith

3.(b) Social Security Number: 216-05-8096

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Emma R. Smith

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): July 8, 1885

8. AGE: Years: 63 Months: Days: If less than one day: hrs. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual occupation: Maintenance man retired

11. Industry or business: Chemical Co.

FATHER
12. Name: Michael Smith
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden name: Mary Hiem
15. Birthplace: Baltimore Md.

16. Informant: Mrs. Emma Smith-wife

Address: 200 5th Ave. Brooklyn Park

17. burial (Burial, cremation, or removal. Which?) Date thereof: March 25/49 (month) (day) (year)

Cemetery or crematory: Holy Cross

Location: Ritchie Highway

18. Funeral director: Krause Funeral Home

Address: 1216 S. Charles St. Balto. 30

19. 3/24 19 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/22/ 1949, at 7 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 25 1949, to Mar 21 1949 and that I last saw h 1M alive on Mar 21, 1949 19

Immediate cause of death: Hypertension Cardio-Vascular Renal Disease — DURATION: ?

Due to: Arteriosclerosis — ?

Due to: 442

Other conditions: 131a

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph S. Blum, Mar M. D. or other

Address: 1115 N. Calvert St. Date signed: 3/23/49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02326

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: ✓ (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Millersville Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Wm Edwards Spriggs

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March 9th 1926

8. AGE: Years: 23 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: ✓

11. Industry or business

FATHER: 12. Name: George Spriggs

13. Birthplace

MOTHER: 14. Maiden name: Alice Greenleaf

15. Birthplace: A A County

16. Informant: Annie Bowie

Address: Gambrills Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 3/49 (month) (day) (year)

Cemetery or crematory: Mt. Tabor

Location: Chesterfield A.A.Co

18. Funeral director: J. B. Johnson

Address: Annapolis

19. April 1 1949 E F Joyce Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 1949 at 3:45 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1948 to 3-31 1949 and that I last saw him alive on Mch 27 1949

Immediate cause of death: Multiple Sclerosis — DURATION: 3 yrs

Due to: History etc not available

Due to: 345

Other conditions: 87d (Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: O H Mas Nemur MD (M. D. or other)

Address: Millersville Md Date signed: 3/31-49

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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RECEIVED
APR 5 1949
BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02327

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS-A15

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN EASTPORT — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN EASTPORT
STREET ADDRESS (If rural give location) 429 SECOND ST

3. NAME OF DECEASED (Type or Print): (First) EDWARD (Middle) A. (Last) TAYLOR

4. DATE OF DEATH: (Month) 3 (Day) 22 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 12-10-1858

9. AGE last birthday: 90 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: CARPENTOR

11. BIRTHPLACE (State or foreign country): ANNAPOLIS MD

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: JAMES B. TAYLOR

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MRS JACOB MEISER

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Dilatation of the Heart — Interval: Immediate

422.1 Antecedent cause(s)

932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic - Cardio-Vascular disease. — Interval: 3 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 6, 1949, to March 22, 1949, that I last saw the deceased alive on March 22, 1949, and that death occurred at 3 P.M., from the causes and on the date stated above.

SIGNATURE Albert Anderson (Degree or title) M.D. ADDRESS Annapolis, Md. DATE SIGNED 3/27/49.

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE 3-24-49 — NAME OF CEMETERY OR CREMATORY CEDAR BLUFF — LOCATION (City, town, or county) ANNAPOLIS — (State) MD

DATE REC'D BY LOCAL REG. March 23, 1949 — REGISTRAR'S SIGNATURE W. F. Lynch

24. FUNERAL DIRECTOR JOHN M. TAYLOR — ADDRESS ANNAPOLIS MD

RECEIVED
MAR 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02328

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park; STREET ADDRESS (If rural, give location) Whitestead-on-the-Severn

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Eugene (Last) Templeton

4. DATE OF DEATH: (Month) Mar. (Day) 19 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Aug. 11, 1911

9. AGE last birthday: 37 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OWN BUSINESS

10b. KIND OF BUSINESS OR INDUSTRY: DRY CLEANING

11. BIRTHPLACE (State or foreign country): Greenport L.I. NY

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Eugene TEMPLETON

14. MOTHER'S MAIDEN NAME: Frances Cleaves

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Paul J. Kesmodel, Severna Park, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Wound in head thru mouth from shot-gun

Antecedent cause(s) (b) Suicide

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

976 164c

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): suicide

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: In woods (CITY OR TOWN): Round Bay, Severna (COUNTY): A. A. (STATE): Maryland

TIME OF INJURY: (Month) Mar. (Day) 16 (Year) 1949 (Hour) 7 m.

INJURY OCCURRED While at Work ☐ Not While At work ☑

HOW DID INJURY OCCUR? Self inflicted single barrel shot-gun wound

Must make a Postmortem Examination

22. I hereby certify that I ~~attended the deceased from~~ ....., 19..., to Mar. 19, 1949, ~~that I last saw the deceased alive on~~ ....., 19..., and that death occurred at 11:45 m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John M. Coffey M.D., Deputy Medical Examiner ADDRESS: Annapolis, Maryland. DATE SIGNED: 3/19/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: 3-22-49 NAME OF CEMETERY OR CREMATORY: Green Hill Cem LOCATION (City, town, or county) (State): Greenport, Long Isld, N.Y.

DATE REC'D BY LOCAL REG.: 3/21/49 REGISTRAR'S SIGNATURE: L. J. Dillon

24. FUNERAL DIRECTOR: Thomas W. Singleton ADDRESS: Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS.A15.

RECEIVED
MAR 23 1949
BUREAU V. S.

02329

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23-

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (In this place) —
HOSPITAL OR INSTITUTION OR STREET ADDRESS none

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY ~~Anne Arundel~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 5013 Catalpha Road.

3. NAME OF DECEASED (Type or Print) (First) Parks (Middle) Frederick (Last) Todd
4. DATE OF DEATH (Month) March (Day) 17 (Year) 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Dec. 24, 1917
9. AGE last birthday 31 yrs. If under 1 year: Months 2 Days 23 If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman
10b. KIND OF BUSINESS OR INDUSTRY Home Improvement
11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Robert F. Todd
14. MOTHER'S MAIDEN NAME Julia Slaysman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) World War II
16. SOCIAL SECURITY NO. 218-81-1714
17. INFORMANT Mrs. Parks F. Todd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bullet wound in head — INTERVAL BETWEEN ONSET AND DEATH: sudden

976 Antecedent cause(s)

164c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) a Count Road (CITY OR TOWN) Glen Burnie (COUNTY) A.A. (STATE) Md
TIME OF INJURY (Month) Mar. (Day) 17, (Year) 1949 (Hour) 3:00 p.m.
INJURY OCCURRED While at Work ☐ Not While At work ☑
HOW DID INJURY OCCUR? self inflicted wound - .25 Cal. Colt an

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination, ~~19~~, to Mar. 17, 1949, ~~that I last saw the deceased alive on~~ ~~19~~, and that death occurred at 3:10 p.m., from the causes and on the date stated above.

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 3/17/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 3/21/49 NAME OF CEMETERY OR CREMATORY Western LOCATION (City, town, or county) Balto Md (State)

DATE REC'D BY LOCAL REG. 3-18-49 REGISTRAR'S SIGNATURE A W Hedrich 24. FUNERAL DIRECTOR Leonard J. Luck - 5305 Harford Rd ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02330

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessup; HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Annapolis Road; MARYLAND; LENGTH OF STAY (in this place) 48 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessup; STREET ADDRESS (If rural, give location) Old Annapolis Rd.

3. NAME OF DECEASED (Type or Print): (First) William; (Middle) David; (Last) Townsend

4. DATE OF DEATH: (Month) March; (Day) 29; (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1901

9. AGE last birthday: 48 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dust cleaner & greaser

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Jessup

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David Townsend

14. MOTHER'S MAIDEN NAME: Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no; (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 1805

17. INFORMANT: Wm. Betty Townsend

212-03

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Haemorrhage — Interval Between Onset and Death: 5 hrs.

443 Antecedent cause(s)

932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive Cardio-Vas. disease — 1 yr

(c) Arterio-sclerosis — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/29/49 19..... to 3/29/49 19....., that I last saw the deceased alive on 3/29/49 19....., and that death occurred at 12 noon m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank Shipley, M.D. ADDRESS Savage, Md. DATE SIGNED 3/30/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE 3/31/49 — NAME OF CEMETERY OR CREMATORY St. Lawrence — LOCATION (City, town, or county) Jessup (State)

DATE REC'D BY LOCAL REG. Mar 31-49 — REGISTRAR'S SIGNATURE Clara Nesbitt

24. FUNERAL DIRECTOR The H. C. White Co. Inc — ADDRESS

VS. A15

RECEIVED
APR 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02331

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ARNOLD; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS ARNOLD M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A.A.C.O; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ARNOLD; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) MINNIE (Middle) BELL (Last) WATT

4. DATE OF DEATH: (Month) 3 (Day) 3 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 10/25-1866

9. AGE last birthday: 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): St JOSEPH MO

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH ROUNCE

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: JOSEPH L. WATT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	16 hrs.
443 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio-Vascular Disease	10 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan' 1, 19 47, to Mar. 3, 19 49, that I last saw the deceased alive on Mar 3, 19 49, and that death occurred at 4 15 p.m., from the causes and on the date stated above.

SIGNATURE James R. Martin (Degree or title) M.D. ADDRESS Annapolis, Md. DATE SIGNED 3-4-49

23. ~~BURIAL, CREMATION~~ REMOVAL (Specify): DATE 3/4/1949; NAME OF CEMETERY OR CREMATORY; LOCATION (City, town, or county) (State): Detroit Lakes Becker Co. Minn.

DATE REC'D BY LOCAL REG. March 4, 1949

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS: John M. Taylor Son Annapolis, Maryland

VS. A15

RECEIVED
MAR 5 1949
BUREAU V. S.

EVIDENCE FOR CHANGE OF AGE & BIRTH DATE IS ON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02332

20

FILM No. G 119 MAR 22 1949

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Friendship — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Friendship — LENGTH OF STAY (In this place): Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
J. J.	EDWIN	WILSON	Mar	11	1949

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days.	If under 24 hrs.: Hours. Min.
Male	White		Dec. 13. ~~1869~~	79 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Farmer.	Chesapeake Beach Md	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Julius Edwin Wilson	Julia Carr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Oswald Wilson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Primary gen. carcinoma of lung.

162 47d

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec. 2, 1948, to March 11, 1949, that I last saw the deceased alive on March 10, 1949, and that death occurred at 6:45 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Emily H. Wilson, M-D.		Lothian.	3/12/49.

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE	NAME OF CEMETERY ~~OR CREMATORY~~	LOCATION (City, town, or county)	(State)
	Mar. 13-49	St James	Tracys	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3/12/49	M. P. Clary Jr. Deputy	C. A. Standiford & Son	Galesville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

02333

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY A.A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN St Margarets
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MD — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN St Margarets
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Francis (Last) Wirth

4. DATE OF DEATH: (Month) 3 (Day) 18 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 7-10-1895

9. AGE last birthday: 53 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret R-R Engineer

10b. KIND OF BUSINESS OR INDUSTRY: R. R.

11. BIRTHPLACE (State or foreign country): St Louis Mo.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Gottlieb Wirth

14. MOTHER'S MAIDEN NAME: Christine C. Felzen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Mrs Charles Goodman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval between onset and death: 15 min

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c) arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: (Was being treated at Mercy Hosp. for the above)

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 16 Mar, 1949, to 18 Mar, 1949, that I last saw the deceased alive on 16 Mar, 1949, and that death occurred at 6:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Donald H. Hunter, M.D. — 53 Cornhill St. Annapolis, Md — 19 Mar 49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) — DATE: 3/21/49 — NAME OF CEMETERY OR CREMATORY: St. Mary's — LOCATION (City, town, or county) (State): Annapolis, Md.

DATE REC'D BY LOCAL REG.: March 20, 1949 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR — ADDRESS: John M. Taylor + Son - Annapolis, Md.

VS. A15

RECEIVED
MAR 23 1949
BUREAU V. S.